RHEUMATOLOGY & OSTEOPOROSIS CENTER OF MEMPHIS, P.C.

1. NAME: _____ 2. AGE: _____

3. REASON FOR SEEING THE DOCTOR: _____

_____

4. PRESENT MEDICATIONS: _____

_____

5. RECENT MEDICATIONS INCLUDING OVER THE COUNTER: _____

6. ALLERGIES TO MEDICATIONS: _____

7. HAVE YOU OR ANY FAMILY MEMBER HAD: (PLEASE CHECK)

	PATIENT	MOTHER	FATHER	BROTHER	SISTER	GRAND-PARENTS	CHILDREN
a. Heart Disease:	☐	☐	☐	☐	☐	☐	☐
b. Hypertension:	☐	☐	☐	☐	☐	☐	☐
c. Lung Disease:	☐	☐	☐	☐	☐	☐	☐
d. High Cholesterol:	☐	☐	☐	☐	☐	☐	☐
e. Diabetes:	☐	☐	☐	☐	☐	☐	☐
f. Cancer:	☐	☐	☐	☐	☐	☐	☐
g. Stroke:	☐	☐	☐	☐	☐	☐	☐
h. Tuberculosis:	☐	☐	☐	☐	☐	☐	☐
i. Arthritis - what kind:	☐	☐	☐	☐	☐	☐	☐
j. Systemic Lupus:	☐	☐	☐	☐	☐	☐	☐
k. Kidney Stones:	☐	☐	☐	☐	☐	☐	☐
l. Hepatitis:	☐	☐	☐	☐	☐	☐	☐
m. Psoriasis	☐	☐	☐	☐	☐	☐	☐

8. CAUSE OF DEATH AND AGE: MOTHER: _____

FATHER: _____

9. OPERATIONS IN THE PAST: _____

_____

10. SERIOUS MEDICAL ILLNESS: _____

_____

11. SERIOUS INJURIES: _____

_____

12. BLOOD TRANSFUSIONS IN THE PAST: ☐ YES ☐ NO WHEN: _____

13. DO YOU SMOKE: ☐ YES ☐ NO HOW MUCH: _____ HOW LONG: _____

14. DO YOU DRINK ALCOHOL: HOW MUCH: _____ HOW LONG: _____

15. SPOUSES AGE: _____ YOUR OCCUPATION: _____

16. DO YOU EXERCISE REGULARLY: ☐ YES ☐ NO DO YOU FOLLOW A SPECIAL DIET: ☐ YES ☐ NO

17. WOULD YOU LIKE A REPORT OF THIS EXAMINATION TO BE SENT TO ANOTHER PHYSICIAN?: ☐ YES ☐ NO

_____

_____

18. ADDITIONAL INFORMATION - (If needed, use back of sheet): _____

_____

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